COLORADO
Department of Health Care Policy & Financing

Out-of-State Pharmacy Questionnaire

This is a copy of the Out-of-State Pharmacy Questionaire, so that providers may gather the neccisary information prior to beginning their enrollment or revalidation application

The Colorado Medical Assistance Program Pharmacy Provider Network is open to pharmacies located within the State of Colorado and certain out of state pharmacies.(10 C.C.R. 2505-10, Section 8.820)

Regardless of the reason why you want to enroll your pharmacy as a Colorado Medical Assistance Program provider, the pharmacy must also meet all requirements outlined in the Medical Assistance Program provider application. To provide the proposed services, the pharmacy must also either be registered with the Colorado Board of Pharmacy or you must certify that your pharmacy does not need to be registered with the Colorado Board of Pharmacy. If your pharmacy is registered, please attach a copy of your Colorado Pharmacy Registration as issued by the Colorado Board of Pharmacy to this application.

In order to provide services to Colorado Medical Assistance Program members, the out of state pharmacy must meet one or more of the following criteria. (Yes/No)

1. Is located in one of the towns that border Colorado's state lines, refer to the Billing Manuals - Appendix F for the list of border towns.
2. Is providing emergency pharmacy services to a Colorado Medical Assistance Program member who is traveling out of state.
3. Is providing services for foster care children or other Medical Assistance Program members who permanently reside in other states and are wards of Colorado.
4. Is providing a service that is not available through pharmacies within Colorado.

If you are enrolling as a Mail Order Pharmacy, please indicate which situation applies. (Yes/No)

1. Providing a product that is not available through pharmacies in Colorado.
    a. If Yes, you will need to list products
2. Required by the member's third party insurance carrier.
3. Member has a physical hardship that prohibits the member from obtaining a maintenance medication from a local pharmacy.
    a. If Yes, you will need to list the Member Name and Member ID

If you are providing emergency services, please indicate the member's name and Medical Assistance Program state identification number. Please estimate the length of time that the member will need such services. The Colorado Medical Assistance Program will reimburse the pharmacy for the drugs dispensed to treat the emergency only.

1. Member Name
2. Member ID
3. Time Estimate

If providing services for foster care children or other Medical Assistance Program members who permanently reside in other states and are wards of Colorado, please indicate below the member's name and Medical Assistance Program identification number. The Colorado Medical Assistance Program will only reimburse the pharmacy for the drugs dispensed to the members listed.

1. Member Name
2. Member ID

If you do not believe that your pharmacy needs to be registered with the Colorado Board of Pharmacy please complete the question below. (Yes/No)

1. I have sufficiently and adequately investigated whether the pharmacy needs to be registered as a pharmacy with the Colorado State Board of Pharmacy and I certify that I do not believe this pharmacy needs to be registered.